Jane J. Chen D.D.S., PC
4175 Statesmen Drive, Suite E, Indianapolis, IN, 46250
Tel (317)578-9696 Fax (317)578-9797

PATIENT REGISTRATION FORM

TODAY'S DATE:_____

PATIENT NAME: First_____Last_____ MI_____ SSN _____-_____-_____

E-mail:_____Cell Phone: ( )_____-_____

Home Phone: ( )_____-_____ Buisiness Phone:( )_____-_____

Mailing Address: Street_____ Apt# _____City/State_____Zip _____

Date of Birth: ___/____/_____ Sex: M F Employer_____Occupation: _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY NOTIFY

Name	***Address***	***Home Phone***	***Cellphone***
_____	_____	_____	_____

INSURANCE

Name of Insured _____ Relationship to patient_____Birthdate _____
SSN _____ Date employed _____Employer _____
Work phone_____Address of employer _____ City_____ State____ Zip_____
Insurance company _____ Group number _____
Insurance company address _____City_____ State___Zip____
Do you have any additional insurance? YES NO Name of Insurance _____
Name of Insured _____ _____ Relationship to patient_____

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

The undersigned hereby authorizes Dr. Chen and staff to perform any diagnostic aids deemed necessary to make a thorough diagnosis of my needs. I also authorize Dr. Chen and staff to perform any and all forms of dental treatment and therapy that may be indicated.

In consideration of treatment rendered the above- named Patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the Patient; however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection cost, interest of 21% APR, court costs and reasonable attorney fees.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

I agree to be contacted by phone, email, fax or U.S. mail to convey information about appointments, lab test results, clarify medication dosages, or answer simple dental or insurance questions. You may leave a message on voice mail. □You may disclose information to following family members and/or non-family members.

	Phone Number	Relationship
Name		

Signature (patient, parent or legal guardian)_____Date _____

Printed Name (patient, parent or legal guardian) _____

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MEDICAL HISTORY

Patient's Name _____
Last First Initial Date of Birth

Physician's name, address and phone _____

Have you been seen by a physician in the past 2 years? YES NO If yes, why? _____

Have you been hospitalized in the past 5 years? YES NO If yes, why? _____

Have you ever had any operations or surgery? YES NO If yes, what condition? _____

Have you ever had prolonged or excessive bleeding that required special treatment? YES NO

Have you ever had any of the diseases or conditions listed below? (Please circle YES or NO)

Heart Problems……..	YES	NO	Sinus Trouble……	YES	NO
- mitral valve prolapse….....	YES	NO	Allergies or Hives……	YES	NO
- heart murmur……..	YES	NO	Diabetes…….	YES	NO
- artificial heart valve…….	YES	NO	Cancer or Tumor……	YES	NO
- heart pacemaker……...	YES	NO	Radiation or Cobalt Tx……...	YES	NO
- congenital heart lesions.....	YES	NO	Chemotherapy……	YES	NO
- heart surgery….....	YES	NO	Arthritis……..	YES	NO
- heart disease or attack…….	YES	NO	Cortisone Medications……..	YES	NO
- heart failure……...	YES	NO	Glaucoma……...	YES	NO
- angina pectoris……	YES	NO	Hepatitis……	YES	NO
Artificial Joints/prosthesis….	YES	NO	Yellow Jaundice……	YES	NO
Rheumatic Fever…….....	YES	NO	Blood Transfusion…….	YES	NO
High Blood Pressure……..	YES	NO	Alcohol or Drug Addiction…	YES	NO
Anemia……...	YES	NO	Hemophilia…….	YES	NO
AIDS (HIV+) …….....	YES	NO	Venereal Disease……	YES	NO
White Patch in Mouth..	YES	NO	Genital Herpes……...	YES	NO
Stroke…….	YES	NO	Cold Sores or Fever Blisters	YES	NO
Kidney Trouble……..	YES	NO	Epilepsy or Seizures……..	YES	NO
Ulcers…….....	YES	NO	Fainting or Dizzy Spells……	YES	NO
Emphysema…….....	YES	NO	Nervous Disorders…….	YES	NO
Enlarged Lymph Node	YES	NO	Psychiatric Treatment……	YES	NO
Chronic Cough……...	YES	NO	Sickle Cell Disease……	YES	NO
Tuberculosis (TB)……..	YES	NO	Thyroid Disease…….	YES	NO
Asthma……..	YES	NO	Hay Fever……...	YES	NO

List all prescription, over-the-counter and herb medications that you are taking and the reason you are taking them. _____

_____

Do you have allergic or other unusual reactions to the following? YES NO If yes, circle:

Penicillin Aspirin Codeine Sulfa Dental Anesthetics Metals Latex

Other allergies (please list):_____

Have you ever taken **Fosama**, **Zometa**, **Aredia**, or any other oral or intravenous treatment (Bisphosphonates) for bone tumors, excessive calcium in your blood, Osteoporosis? YES NO

If yes, please indicate the name of the drugs_____

Have you ever taken the appetite suppressant **phentermine** and **Phen-fen**? YES NO

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Do you smoke, chew, use snuff or any other forms of tobacco? YES NO

if yes, how many years and how many packs?_____

Do you have family history of sleep-disorder-affected breathing? YES NO
Do you have frequent complaints of unrefreshing sleep and daytime sleepiness? YES NO
Do you have history of snoring, especially loud snoring? YES NO
Have you experienced sleep punctuated by episodes of choking, gasping, breath holding or snorting? YES NO

Do you have any other disease or condition not mentioned above? ..... YES NO
If yes, list:
_____

WOMEN ONLY:

Are you currently pregnant or breastfeeding? YES NO
If yes, what trimester are you in? (How many weeks pregnant are you?) _____
Do you experience morning sickness? YES NO
Are you taking birth control pills or using other contraceptive medications? YES NO
Are you on hormone replacement therapy? YES NO

DENTAL HISTORY

Purpose of initial visit _____
Have you make regular visits? …… YES NO
How often: 3 months 4 months 6 months
How long since your last dental visit? _____
What was done at your last dental visit? _____
When was the last time your teeth were cleaned_____
Previous dentist's name _____
Address: _____

CAVITY RISK ASSESSMENT:

Fluoride Exposure : YES NO If yes, please check: o drinking water o toothpaste o supplements o home fluoride gel/rinse o office fluoride application	Sugary or Starchy Foods or Drinks (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups) YES NO
Are your teeth sensitive to hot, cold, sweets or pressure? YES NO Does food or floss catch between your teeth? YES NO Is your mouth dry? YES NO	Cavities in last 2 years YES NO Teeth missing in past 2 years due to cavities YES NO

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GENERAL QUESTIONS:

Have you ever had any problems or complications with previous dental treatment? …… YES NO
Are any of your teeth loose, tipped, shifted or chipped? …… YES NO

How often do you brush your teeth? 1x/day 2x/day After each meal
What kind of toothbrushes do you use? Manual Electric
How often do you floss your teeth? 1x/day 2x/day After each meal

Have you lost any teeth/have any teeth been removed? …… YES NO
Why? _____
Have they been replaced? …… YES NO
Are you happy with the replacement? …….. YES NO
If no, explain _____

TMJ :

Do you clench or grind your teeth?.....YES NO
Does your jaw click or pop?..... YES NO
Have you experienced any pain or soreness in the muscles on your face or around your ear?.....YES NO
Do you have frequent headaches, neck pain or shoulder pain? ……..... YES NO

PERIODONTAL DISEASE:

Do your gums bleed when you brush and floss?..... YES NO
Do you feel your breath is offensive at times? ……..... YES NO
Have you had any periodontal treatments in the past?..... YES NO

SMILE ANALYSIS:

Are you interested in a free *Smile Design* Consultation?..... YES NO

To the best of my knowledge, all of the information provided on both sides of this registration form is correct.

_____ _____

Signature of Patient, Parent or Legal Guardian ***Date***